TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CYNTHIA L TAYS DC

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-15-2289-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to [injured employee] on January 20, 2014, this request was in response to a $749.10 reduction of the $901.76 for the FCE Designated Doctor Referred Exam performed on March 21, 2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: $152.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. After review, Coventry stands by the pricing reductions. 97750 16 Unit Of Service billed … Second evaluation hence 8 units allowed. Per review of history: DCN 2014044GJ000262 02/10/14 97750 16 Unit Of Service (4 hours)

3/21/14 Split all 16 Unit Of Service however same 8 UOS allowed appropriately … Bill is priced correct."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2014	CPT Code 97750	$152.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - BL – This bill is a reconsideration of previously reviewed bill. Allowance amounts do not reflect previous payments
   - BL – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, or the providers PPO Contract
   - BL – Obtain 24-7 information on the status of your bill via Coventry workers comp services provider portal at www.directprovider.com
   - BL – Section 413.042 of the Texas Labor Code prohibits a provider balance billing an injured worker for workers compensation compensable services except care described u
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a recon is requested
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - W3 – Request for reconsideration
   - ZE10 – W3 Request for reconsideration
   - P12 – no denial given

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is March 21, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 24, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Sandra Hernandez	4/30/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.